

Federal and State Legislative Update 2010

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Agenda: Federal Law

- What's happening in healthcare reform?
- Children's Health Insurance Reauthorization Act of 2009 (CHIPRA)
- COBRA premium subsidy
- Mental Health Parity Act (MHPA)
- Genetic Information Nondiscrimination Act (GINA)
- Michelle's Law
- HITECH

Agenda: Nebraska State Law

- 2009 Enacted Laws
 - LB 551 – continuation of coverage for children
 - LB 358 – changes to the Comprehensive Health Insurance Pool (CHIP) Act
- 2010 Carry-over bills
 - LB 149, 159, 378, 493, 637
- 2010 New bills
 - LB 693, 698, 813, LR289CA, 1017, 1088
- Questions & Answers

Healthcare Reform: Procedure

- Democrats no longer have a 60-vote super majority needed to defeat a GOP filibuster
- Leaves the Democrats with a few options:
 - No bill
 - A “skinny” bill (basically start over)
 - House passes the Senate bill as is (not going to happen)
 - House passes a modified Senate bill with a budget reconciliation amendment (most likely)
- President introduced a new plan attempting to find compromise b/w House and Senate plans
- Congress using the President’s \$950B plan to craft a reconciliation bill, aka “The Big Bill”

Healthcare Reform: Reconciliation

- What's a reconciliation bill? Reconciliation bills are spending bills – all provisions must relate to the budget
- House won't pass the Senate bill as is, so you need a separate reconciliation bill to make changes
- Question: How do you make all the healthcare provisions you want relate to the budget?
- Fear: end up with a piecemeal bill if some provisions are ruled out-of-order (non-budgetary), which is why so many members are leery of the idea.

Healthcare Reform: Reconciliation (2)

- Speaker Pelosi said the House is willing to pass the Senate bill with the additional reconciliation bill
- But Senate cannot pass a reconciliation bill before the House does – revenue measures must start in the House
- Scenarios
 - House would pass the reconciliation bill followed by the comprehensive Senate bill
 - The Senate has to pass the exact same reconciliation bill
 - If the Senate makes any changes, you have to go back through committee and move to conferencing
 - Assuming both bills make it through, the President would sign the Senate bill followed by the reconciliation bill, which would amend the Senate bill.

Healthcare Reform: Timeline

- If the House passes the Senate bill/ reconciliation bill package, Senate would only need 51-votes for final passage
- Senator Nelson has not ruled out voting for a bill under a reconciliation process
- New Timeline: reconciliation instructions expire when Congress passes the next budget resolution, which usually happens in April
- Easter break is only 4 weeks away

Healthcare Reform: President's Plan

Healthcare Reform: President's Plan

(2)

- Fills the Medicare Part D “donut hole” completely
 - Replaces the \$500 increase in the initial coverage with a \$250 rebate to Medicare beneficiaries who reach donut hole in 2010
 - Closes donut hole by phasing down the coinsurance so it is the standard 25% by 2020 throughout the coverage gap
- Requires “grandfathered” plans to cover preventive services w/ no cost sharing beginning 2018
- Individual mandate
 - \$325 in 2015; \$695 in 2016; or alternative payment amount of
 - 1% in 2014; 2% in 2015; and 2.5% in 2016 and subsequent years

Healthcare Reform: President's Plan

(3)

- \$40 billion small business tax credit
- Assessment tax for employers with 50 or more employees
 - Subtract out first 30 workers from payment calculation
 - Payment amount is \$2,000 per full-time worker if the employer does not offer coverage
 - 90-day limit on waiting periods beginning in 2014
- Provisions to crack down on waste, fraud and abuse
- \$67 billion assessment tax on health insurers starting in 2014
- \$35 billion tax on pharma over 10 years starting 2011

Healthcare Reform: President's Plan

(4)

- 40% tax on insurers offering “Cadillac” plans beginning 2018
 - \$10,200/individuals
 - \$27,500/families
 - **Indexed at general inflation plus 1 percent
- 2.9% Medicare Hospital Insurance (HI) tax on high-income households
- Additional 2.9% tax on income from interest, dividends, annuities, royalties and rents, other than ordinary income, on taxpayers with income above \$200,000/individuals and \$250,000/married
- Federal assistance for families making up to \$88,000

Healthcare Reform: House Provisions

- Guaranteed issue required for all markets (generally consistent with current small group requirements)
- Age band rating set at 2:1
- No pre-ex for all markets – between 1/1/10 and 2013, limits pre-ex to 3-month exclusion and 30-day look-back for group markets
- Reinsurance for early retirees (ages 55-64) with employer coverage
- Temporary national high-risk pool ending with operational Exchange – premiums set at 125% with 2:1 age band
- COBRA extended until operational Exchange (2013)

Healthcare Reform: House Provisions

(2)

- National Exchange with limited state ability to opt-out and operate a state or regional-based Exchange
- CHIP enrollees allowed into Exchange in 2014
- Small employers with 25 or fewer employees allowed in Exchange in Year 1 and 50 or fewer in Year 2
- Exchange eligibility could be expanded to larger employers in Year 3
- Essential benefits package and tiered benefit packages required for Exchange beginning at 70% actuarial value
- All products outside Exchange must meet essential benefits package and have 70% actuarial

Healthcare Reform: House Provisions

(3)

- New Medicare-like government plan to compete with private plans
- HHS is allowed to negotiate payment rates with providers
- \$5 billion for state-based non-profit co-ops
- Individual mandate with penalty of 2.5% modified adjusted gross income
- Employer mandate
 - Penalty of 8% payroll and
 - 8% tax on average employee wages for employee that declines employer coverage and enrolls in the Exchange.

Healthcare Reform: House Provisions

(4)

- Small employers w/ payroll under \$500K exempt.
- Individual subsidies for persons earning up to 400% FPL
- Medicaid expansion to 150% FPL
- Repeals CHIP funding effective October 31, 2013. Gradual phase-out. CHIP children above 150% FPL go to exchange and below 150% FPL to Medicaid
- Medicare Part D 'donut hole' gets phased-out by gradually increasing the initial coverage limit and decreasing annual out-of-pocket expenses
- Cuts about \$500 billion from Medicare

Healthcare Reform: Senate Provisions

- Note: similar to House bill except for noted provisions.
- Age band rating set at 3:1
- Temporary national high-risk pool premiums are 100% standard rate with 4:1 age band
- State-based Exchanges (rather than national) established. Allows for continued offering of individual and group coverage outside Exchanges.
- Small group Exchange eligibility defined as 1-100 workers beginning 2014 (optional 1-50 until 2016).
- State can allow large employers (100+) to purchase coverage in the exchange beginning in 2017

Healthcare Reform: Senate Provisions

(2)

- Essential benefits package actuarial value begins at 60%
- Individual mandate with \$95 penalty beginning in 2014, graduating in 2016 to \$750 or 2% of income, whichever is greater (adjusted for cost of living).
- Employer mandate with \$750 penalty per full-time worker
- Medicaid expansion to 133% FPL
- Maintains CHIP program

Healthcare Reform: Senate Provisions

(3)

- Raises Medicare part D ‘donut hole’ initial coverage limit point by \$500 in 2010
- 40% excise tax on insurance companies selling Cadillac plans (\$8,900/individual and \$24,000/family); unions exempted until 2017
- BCBSNE and other mutual insurance companies are waived from the annual assessment tax imposed on health insurers, so long as medical loss ratio is not less than 89% after 2011

“Grandfathered” Plans

- ALL individual health insurance coverage that is not grandfathered may only be offered through the Exchange (House)
- Grandfathering status is indefinite but ends if any benefit, cost-sharing, or other change is made to coverage (House)
- Grandfathered policies are those in effect at the time the Exchange becomes operational (House)
- Grandfathered policies are those in effect at time of bill’s enactment (Senate)

Effect on Brokers and Agents

- House bill states that the role of agents and brokers should not change under State law, including with regard to the enrollment of individuals and employers in qualified health benefit plans
- Senate allows states to use agents/brokers to enroll individuals in Exchange coverage but gives HHS Sec. power to set broker commission rate schedules

Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)

- February 4, 2009 – President Obama signed into law
- Act extends and expands CHIP by adding \$33 billion in federal funds for children's coverage over the next four and a half years
- Expected to provide coverage to 4.1 million children in Medicaid and CHIP who otherwise would have been uninsured by 2013

CHIPRA (2)

Who is covered under CHIPRA?

- CBO estimates that CHIPRA would provide coverage to an additional 6.5 million children in CHIP and Medicaid in 2013
- CHIPRA establishes new options to cover pregnant women
 - CHIPRA limits current coverage for adults and prohibits new waivers for parent coverage
 - States currently covering parents could continue these waivers through FY2011
 - After that, the bill would create a set-aside separate from the CHIP program for parent coverage that would be available to states at the Medicaid match
- CHIPRA allows states the option of providing coverage to legal immigrant children and pregnant women during their first five years

CHIPRA (3)

State Incentives

- CHIPRA includes fiscal incentives for states to enroll eligible low-income children in Medicaid
- States could qualify for a bonus per child based on how far actual enrollment exceeds target levels
- CHIPRA also creates a contingency fund available for states if spending exceeds allotments for CHIP due to increased enrollment

CHIPRA (4)

Benefit Requirements

- CHIPRA requires states to include dental services in CHIP plans
- Would allow states the option to provide dental-only supplemental coverage for children who otherwise qualify for a state's CHIP program but have other health insurance without dental benefits
- Requires mental health parity for states that chose to include mental health or substance abuse services in CHIP plans

CHIPRA (5)

Financing

- Each state will continue to receive an annual allotment and states can receive matching funds for CHIP up to that capped amount
- CHIPRA replaces the current allocation formula with one that relies on state's actual and projected spending increased by factors for inflation and child population growth

COBRA Premium Subsidy

American Recovery and Reinvestment Act (ARRA)
signed by President Obama February 17, 2009

- Includes a subsidy of 65% of the state or federal continuation coverage premiums for 9 months for assistance eligible individuals who were involuntarily terminated between 9/1/2008 and 12/31/2009
- Employer or insurer can recover the subsidy payment claiming a credit as an offset against their federal payroll taxes
- Applies to employers and in some cases

COBRA Premium Subsidy (2)

Department of Defense Appropriations Act, 2010 signed by President Obama on December 19, 2009

- Subsidy extended to fifteen months (from original nine months).
- Eligibility period extended through 2/28/2010. (may be extended to 6/30/2010 – in H.R. 2847, which has passed the House and is pending in the Senate. On Tuesday, Senate voted to extend the subsidy 30 days.)
- Eligibility now based on date of termination from employment (not when continuation coverage begins).
- Individuals whose initial subsidy ended and who either dropped coverage or who paid full cost are eligible for subsidy extension period (up to 15 months).
- New notices must be provided by employers/insurers.

COBRA Premium Subsidy (3)

Entity Responsible for Subsidizing Coverage/ Eligible for the Payroll Tax Credit

- Multiemployer plan
- Employer subject to COBRA (self insured or fully insured plan)
- Insurer if it's state continuation coverage

COBRA Premium Subsidy (4)

Assistance Eligible Individuals

- Employees are eligible for the subsidy if they:
- Were involuntarily terminated from employment between 9/1/08 and 2/28/10,
AND
- Are otherwise eligible for COBRA or state continuation
- Spouses and dependents are also eligible

COBRA Premium Subsidy (5)

Period of Coverage

- The subsidy is now available for fifteen months (originally 9 months).
- Maximum period of COBRA coverage is not extended.
- An individual ceases to be eligible for the subsidy on the date the individual becomes eligible for other health plan coverage OR on the date which the COBRA or other continuation coverage expires OR after the expiration of 9 months, whichever is earliest.
- If an individual took advantage of the extended election period, a lapse in coverage for purposes of creditable coverage cannot be taken into account.

COBRA Premium Subsidy (6)

Alternate Coverage Option

- An employer may allow an assistance-eligible individual to elect coverage different from the coverage the individual was enrolled in prior to the involuntary termination.
- The premium for coverage under the new option cannot exceed the premium for the coverage the individual was enrolled in prior to the involuntary termination.
- The coverage offered under this option

COBRA Premium Subsidy (7)

State Continuation

- It remains the employers' responsibility to send notice/ election form/subsidy application to involuntarily terminated employees.
- Employees need to complete the election form and subsidy application and return them, along with 35% of the premium, to the insurer. (BCBSNE process)
- The insurer will subsidize the remaining 65% and receive the tax credit through payroll taxes

Mental Health Parity Act (MHPA)

- 10/3/2008 – Former President Bush signed into law H.R. 1424, which included the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.
- Effective for plan years beginning on or after 10/3/2009.
- This law requires parity between mental health/ substance abuse benefits and medical/surgical benefits.
- It does NOT mandate coverage for mental

MHPA (2)

Interim Final Regulations were issued
February 2, 2010 (75 Fed. Reg. 5410)

- Regulations generally apply for plan years beginning on or after July 1, 2010
- For collectively bargained plans that had an agreement that was ratified before Oct. 3, 2008, regulations apply for plan years beginning the later of the date on which the collective bargaining agreement terminates (without extensions) or July 1, 2010

MHPA (3)

Parity Requirements: Requires parity with respect to both treatment limitations and financial requirements

- Prohibits plans from applying specific financial requirements or treatment limitations to mental health or substance use disorder benefits that are more restrictive than the *predominant* (most common or frequent) financial requirements or treatment limitations applied to *substantially all* medical/surgical benefits
- Financial requirements are defined to include deductibles, copayments, coinsurance or out-of-pocket limits.
- Treatment limitations include limits on frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment.

MHPA (4)

Regulations identified 6 classifications of benefits:

- Inpatient, in-network
- Inpatient, out-of-network
- Outpatient, in-network
- Outpatient, out-of-network
- Emergency care
- Prescription drugs
 - These are the only classifications used

MHPA (5)

A plan must provide MH/SUD benefits in each classification in which it provides medical/surgical benefits

- The complete exclusion of coverage in a classification is considered a treatment limitation
- Inpatient, outpatient and emergency care are defined by the plan – must be applied uniformly

MHPA (6)

In measuring plan benefits an analysis must take place.

- Part 1 – A requirement/limit applies to *substantially all* medical/surgical benefits in a classification if it applies to at least 2/3 of the benefits in that classification
- Part 2 – The *predominant level* is the one that applies to more than 1/2 of medical/surgical benefits subject to the requirement/limit in that classification

The analysis must be performed by coverage unit (i.e. employee, employee + 1, family)

MHPA (7)

Prescription Drug Benefits

- A plan that imposes different levels of financial requirements on different tiers of prescription drugs based on reasonable factors and without regard to whether a drug is generally prescribed with respect to medical/surgical or MH/SUD benefits satisfies the parity requirements.

MHPA (8)

Nonquantitative Treatment Limitations must be comparable to, and applies no more stringently than those applied to medical/surgical benefits

- Non-exhaustive list of examples:
 - Medical management
 - Prescription drug formulary design
 - Standards for provider admission to participate in a network, including reimbursement rates
 - Determinations of UCR amounts
 - Fail-first or step therapy protocols

MHPA (9)

Out-of-Network Coverage

- Plans are required to provide out-of-network coverage for mental health and substance abuse in a manner consistent with out-of-network coverage for medical/surgical benefits.

Small Employer Exemption

- Exemption for small employers, defined as those with 2-50 employees.

Cost Exemption

- If the parity requirement causes total health plan costs to increase by 2% in the first plan year (1% in subsequent years), the parity requirements may not apply the following plan year. Requires plans to comply with the parity requirements at least 6 months before a cost exemption determination can be made. (Administratively very burdensome.)

Genetic Information Nondiscrimination Act (GINA)

- Signed into law by former President Bush on May 21, 2008.
- Effective for plan years beginning after May 21, 2009.
- Prohibits health insurance companies from denying coverage or to charge a higher rate or premium to an otherwise healthy individual found to have a genetic predisposition to a disease or disorder.
- Makes it illegal for employer's to use an

GINA (2)

What is “genetic information?”

- Information about an individual or his or her family’s genetic test(s).
- Information about a family member’s *manifested* disease or disorder (“family members” defined liberally – dependents and 4th degree relatives included).
- Includes requests regarding “genetic services.”
- Genetic testing, genetic counseling, genetic education.

GINA (3)

What are “genetic tests?”

- Analysis of human DNA, RNA, chromosomes, proteins, or metabolites that detects genotypes, mutations, or chromosomal changes.
- Does not include:
 - Analyses that do not detect genotypes, mutations or chromosomal changes.
 - Analyses directly related to a manifested disease or disorder.

GINA (4)

Prohibitions for Group Plans

- Increasing group premiums or denying enrollment based on genetic information.
- Cannot request or require an individual or family member of the individual to undergo a genetic test.
- Cannot request, require or purchase, use or disclose genetic information for underwriting purposes.
- Incidental Collection Exception: Not a violation if genetic information is obtained

GINA (5)

Prohibitions for Individual Plans

- May not establish rules for eligibility (or continued eligibility) to enroll based on genetic information.
- May not adjust premium or contribution amounts on the basis of genetic information concerning the individual or a family member of the individual.
- May not impose any preexisting condition exclusion on the basis of genetic information.

GINA (6)

- Interim Final Regulations effective for plan years beginning on or after December 7, 2009
- Clarified that “genetic information” includes family medical history.
- Regulations define “underwriting purposes” to include:
 - Rules for, or determination of, eligibility for benefits under the plan or coverage;
 - Computation of premium or contribution amounts under the plan or coverage;
 - Application of any preexisting condition exclusion under the plan or coverage;
 - Other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefit.

GINA (7)

- Based on definition, plans cannot provide a monetary incentive for completing a Health Risk Assessment (HRA) that requests family medical history
- In regard to HRAs, any request for genetic information (including family medical history) cannot occur before the effective date of coverage; and any request for genetic information (including family medical history) cannot be tied to a reward.

Michelle's Law

- Signed into law by former President Bush on October 9, 2008.
- Effective for plan years beginning on or after October 9, 2009.
- Requires group and individual health plans to continue to cover otherwise eligible dependent children taking a medical leave of absence from a postsecondary educational facility due to a serious illness or injury, provided the illness or injury is certified by a treating physician of the dependent child.

Michelle's Law (2)

Who is a dependant child?

- A dependent child, under the terms of the plan or coverage, who was enrolled in the plan on the basis of being a student at a postsecondary educational institution immediately before the first day of the medically necessary leave of absence.

What is a medically necessary leave of absence?

- A leave of absence of a dependent child from a postsecondary education institution that commences while such child is suffering from a serious illness or injury, is

Michelle's Law (3)

Physician Certification

- The law requires a written certification from the child's treating physician that the dependent child is suffering from a serious illness or injury and that the leave of absence is medically necessary.

Duration

- The dependent child will be covered until the earlier of one year from the first day of the leave of absence or the date on which the coverage would otherwise terminate.

Benefits

- The dependent child will receive the same plan benefits as he or she did prior to the leave of absence, and if the plan changes, the dependent child will receive the benefits as provided by the changed plan.

LB 551

The Law

- Effective January 1, 2010
- Allows for continuation of coverage for children to age 30
- The law applies to:
 - all fully-insured group policies;
 - non-ERISA self-funded employee benefit plans;
 - individual policies

LB 551 (2)

Eligibility

- Subscriber may elect to continue coverage for a dependent to age 30 if:
 - the dependent ceases to be a full-time student; or
 - reaches an age which exceeds the specified age at which coverage ceases under the plan
- Child must be remain financially dependent on the subscriber and be covered as a dependent under the plan as of January 1, 2010

LB 551 (3)

Election of Coverage

- Law allows insurers to require an election form be completed in order to obtain coverage.

Cost for Coverage

- Subscriber will be charged additional premium equal to that of a single adult under the plan
- Employers are not required to make any premium contribution for this coverage

LB 551 (4)

- If election of this coverage would cause a change in the coverage class, premium will be adjusted
 - Example: If employee, spouse and child were covered under a family membership, the premium class would change to employee-spouse + an additional single adult premium
 - This may not be the approach/interpretation taken by all insurers
- Note: Even though the dependent will be charged a separate premium, his/her eligible expenses will continue to apply toward satisfaction of calendar year deductible and coinsurance amounts under the subscriber's plan
 - Example: In the example above, the child's eligible expenses would apply toward satisfaction of the family deductible and coinsurance amounts

LB 551 (5)

Termination of Coverage

- The law allows for termination of coverage if the covered individual:
 - marries;
 - ceases to be a resident of Nebraska;
 - receives coverage under another health benefit plan or self-funded employee benefit plan; or
 - turns 30 years old.

LB 551 (6)

Various Insurer Interpretations of LB551

- One approach has been to revise the definition of Eligible Dependent to include all dependent children to age 30. Therefore, this is not continuation coverage, but rather an expansion of the insurer's Eligible Dependent definition.
- Another approach has been to treat the continuation similar to COBRA and provide the LB551 individual with their own certificate of coverage, therefore having a separate deductible, coinsurance limit, etc.

HITECH

- Overall, has an impact on HIPAA in a number of areas

Enforcement Strengthened

- Increases the penalties that may be imposed for violations for the rules from \$25,000 to as much as \$1.5 million
- AGs now have authority to enforce HIPAA rules, limited primarily to amount that can be sought by AGs
- Permits enforcement actions against individuals employed by healthcare

HITECH (2)

Security Breach Notification

- New notification for healthcare industry
 - Applies to breaches of personal health information held by healthcare companies
 - Requires Covered Entities to perform risk of harm assessment to determine if breach occurred
- Requires reporting of a wide range of security breaches
- Went into effect on February 17, 2010

HITECH (3)

Extension of HIPAA Requirements to Business Associates

- Likely extend full compliance responsibility for HIPAA Privacy and Security Rules to the business associate category (i.e., companies providing services to healthcare industry)
- Obligates business associates to follow all HIPAA provisions (not limited to EHR)

HITECH (4)

Restrictions on Sharing Healthcare Information for Self-Pay Situations

- Permits individuals to request of their healthcare provider that the provider not disclose information to an insurer for payment or healthcare operations purposes, if the patient has paid for the service out-of-pocket
- While no direct compliance issues for health plans, plans will need to analyze how this could affect claims payment and underwriting

HITECH (5)

Limited Data Sets and Minimum Necessary

- Mandates that HIPAA covered entities examine “to the extent practicable” whether a “limited data set” can be used for the disclosure of healthcare information
- Limited Data Set: healthcare information that has been almost de-identified
- Appears to insert a new admin step for all uses and disclosures to determine whether a limited data set could be used

HITECH (6)

Accounting and Access Rules

- Expands the accounting rule
- If company uses EHR, it will have to track for accounting reasons all disclosures of information for treatment, payment and health operations purposes
- Likely imposes a significant burden for healthcare companies using EHR
- Individual right to access is expanded by this legislation where an EHR is used

HITECH (7)

Marketing Provisions

- Clarifies that “marketing” communications will be considered “healthcare operations” only if they meet specific criteria in the rule
- Requires an authorization even for communications permitted by the HIPAA privacy rules if the covered entity receives “direct or indirect” payment for the communication
- Statutory Ambiguity: What constitutes “indirect” payment for a communication?

HITECH (8)

State Law and Privileges

- Does nothing to alter the current “preemption” status of the HIPAA rules
- State laws will continue to govern if they are “more stringent” than the relevant HIPAA provision

HITECH: BCBSNE's Efforts

- Updated business associate agreements to include HITECH language
 - Included HITECH as cited regulation to notify the business associate of its compliance responsibility
 - HITECH required termination rights for the business associate, reference to the business associate's obligation to comply with all HIPAA requirements, and a requirement to use electronic PHI to satisfy minimum necessities whenever possible
- Updated security policies to include the new

LB 358

- Bill makes various changes throughout the Comprehensive Health Insurance Pool (CHIP) Act
- Purpose of slowing growth of the pool's net loss and keeping CHIP solvent
- Provisions
 - Requires CHIP board of directors to review operation of the pool and report on cost savings
 - Grants CHIP board authority to establish provider reimbursement for benefits payable

LB 358 (2)

- Provisions (cont'd)
 - Ineligible if eligible for group coverage or has not exhausted COBRA coverage
 - Prohibits an insurer, agent, broker, or third-party administrator from referring an individual employee to the pool or arranging for an individual employee to apply for pool coverage for the purpose of separating that individual employee from group health coverage connected to the person's employment.

LB 358 (3)

- Revises calculations to determine rates charged to CHIP individuals:
 - Increase number of insurers used to calculate standard risk rate from five to ten
 - Repeal below-market rate established for individuals under the age of 18
 - Increase multiplier used with standard risk rate from 135 percent of standard risk rate to 150 of standard risk rate in 5 percent increments over 3 years
 - Specifies that rate charged shall be either new figure or previous year's rate increased by

State Carry-Over Bills

- LB 149 (Pankonin):** Require insurance coverage for prosthetics as prescribed
- LB 149 would require that the most appropriate prosthetic, deemed medically necessary by a treating physician, be covered by insurance plans in the state of Nebraska, at a minimum, equal to coverage provided in the federal Medicare program.
 - The bill would not prevent application of deductibles or co-payment provisions contained in the insurance plan or require

State Carry-Over Bills (2)

- LB 159 (Gay):** Provide an income tax credit for long-term care insurance policy premiums
- Allows a nonrefundable income tax credit equal to 25% of premiums paid for a long-term care insurance policy.
 - The total credit could not exceed \$250 for individual policies and \$500 for joint policies.
 - The credit may be claimed for a maximum of three years.

State Carry-Over Bills (3)

LB 378 (Gloor): Require insurance coverage of medical clinical trials

- Mandates that private insurance and self funded employee benefit plans, to the extent not preempted by federal law, provide coverage of routine care when the patient is receiving treatment in a federally approved clinical trial.
- Coverage of routine care for the patient would be the same coverage as outlined in their insurance policy that would be in effect if they were not a participant in a clinical trial.
- NOT include any expense of a drug or device, physicians, clinicians, administration, or data collection of the clinical trial, or incidental expenses such as housing or travel.

State Carry-Over Bills (4)

LB 493 (Karpisek): Require insurance coverage for cochlear implants

- Legislative Bill 493 requires insurance coverage for single or bilateral cochlear implants for persons diagnosed with severe to profound hearing impairment.

State Carry-Over Bills (5)

LB 637 (Mello): Require disclosure of information by certain group health carriers

- Requires insurers or other entities that issue group health benefit plans of fifty-one or more eligible employees to provide information, on an annual basis, that would include:
 - The total amount of claims paid, including claims experience for medical, dental, pharmacy benefits,
 - The total number of covered employees on a monthly basis by coverage tier,
 - Total number of covered employees that have reached their deductible by tier,

State Bills 2010

- LB693 (Price):** Authorizes foreign insurers to offer health insurance in Nebraska through interstate agreements or by authority of the State.
- Any foreign insurance company or association proposing to offer sickness and accident insurance in the State of Nebraska must receive authorization to do business in this state as provided in the interstate agreement.
 - The Legislature recognizes the need for individuals, employers, and other purchasers of health insurance in this state to have the opportunity to choose health insurance policies that are more affordable and flexible than existing market policies of sickness and accident insurance coverage.

State Bills 2010 (2)

LB 693 (cont'd)

- The Director of Insurance, in consultation with the Attorney General, may enter into interstate agreements with other willing states to authorize the issuance of sickness and accident insurance policies by foreign insurers from such states.
- So long as the Director and Attorney General approve of the foreign company's state laws, foreign insurers authorized to offer or issue a sickness and accident insurance policy shall not be required to offer or provide health insurance coverage required by Nebraska law or rules and regulations adopted pursuant to Nebraska law except for specified requirements in the bill.

State Bills 2010 (3)

LB698 (Louden): strikes out certain taxes on insurers, including 5% capitation payments made in accordance with the Medical Assistance Act.

- The bill also excludes any capitation payments that are made in accordance with the Medical Assistance Act in the computation of tax obligations imposed by the bill.
- Finally, the bill repeals taxes paid for capitation payments made in accordance with the Medical Assistance Act remitted

State Bills 2010 (4)

- LB813 (Gloor):** Prohibit prepaid dental service plans from limiting fees for certain services
- Legislative Bill 813 adds language stating that no prepaid dental service plan offered in this state shall limit any fees charged for services that are not covered by the plan.

State Bills 2010 (5)

- LR289CA (McCoy):** Constitutional amendment to prohibit laws that restrict or interfere with choice of health care plans or direct payment for medical services
- Legislative Resolution 289CA states:
 - All people should have the right to make decisions about their health care
 - (1) Can't restrict a person's freedom of choice of private health care systems;
 - (2) Can't Interfere with a person's right to pay

State Bills 2010 (6)

LB 1017 (Cornett): Provide requirements for insurers for prescription drug coverage

- The purpose of LB1017 is to keep the down cost of certain drugs, such as infusible biologics or plasma-derived therapies
- The bill prohibits insurers from creating specialty tiers that require payment of a percentage cost of prescription drugs
- An insurer shall not charge a copay that exceeds the lowest cost prescription drug copay by 500%

State Bills 2010 (7)

LB 1017 (cont'd)

- If the insurer includes an out-of-pocket limit for benefits other than prescription drugs, the insurer has to include one of the following provisions that would result in the lowest out-of-pocket prescription drug cost:
 - Out-of-pocket expenses for prescription drugs shall be included under the plan's total limit for out-of-pocket expenses for all benefits provided under the plan; or
 - Out-of-pocket expenses for prescription drugs

State Bills 2010 (8)

LB 1088 (Cornett): Adopt the Physician and Patient Prescription Protection Act

- The bill specifies processes for notifications of request for medication changes, including the information to be included with the change, any economic reasons for changing the medication, and patient rights before changing medication.

State Bills 2010 (9)

LB 1088 (cont'd)

- The bill states:
 - “Health insurance premium payors and employers responsible for paying the health care premium or portions thereof shall be notified of medication change programs adopted by health carriers and pharmacy benefit managers in any plan offered by such premium payor or employer.
 - Such notification shall include any financial incentives a health carrier or pharmacy benefit manager may be utilizing to encourage

Questions and Answers

Questions?

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